Medical Record Chart review requirements printed out for Designation Review

Designation reviews running records using ICD 10 codes: Run codes from **S00-T79.9**

Please have paper copies of the following if applicable for chart review;

1. PI face sheet with general information including ISS, ED Dwell time, DX (can be an excel spreadsheat)
2. EMS PCR (run report or trip report)
3. ED trauma flow sheet
4. If no trauma flow sheet, nursing documentation can be summative
5. ED provider documentation/H & P
6. Trauma Surgeon's note/ H & P (if applicable)
7. OR documentation (if applicable)
8. ICU flow sheets (if applicable)
9. Radiology reports
10. Consult Reports (if applicable)
11. Discharge summary
12. Autopsy (if applicable)
13. Follow-up from referring facility

Performance Improvement is a focal point of an effective trauma program. During the review of the facility's performance improvement, the reviewers would like to see issue identification, levels of review, corrective action plans, methods of monitoring and re-evaluation and loop closure. Problem resolution, outcome improvements and loop closure must be identifiable. Please have this in the patient's record for the reviewers.

Medical Records Chart categories of the paper medical records

All Deaths

All Transfers Out

Abdominal Injuries

ISS >15 and admitted to your facility

orthopedic injures admitted to your facility

Pediatric patients < 15 years of age

No Trauma Team Activations